

## CERTIFICATE OF DEATH

Reg. Dist. No.

00532

534

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Potomac Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 Cypress Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Catherine</u> Middle <u>Armstrong</u> Last		4. DATE OF DEATH <u>January</u> Month <u>24</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James O'Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Julia Shedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Frank Armstrong (son)</u> Address <u>28 Cypress Pl., Potomac Heights</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>34 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage Oct 1959</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14, 1961</u> , to <u>Jan 24, 1961</u> , that I last saw the deceased alive on <u>Jan 14, 1961</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u>		DATE SIGNED <u>1-24-61</u>	
ACTUAL SIGNATURE <u>Frank G. Pagan</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		<u>Indian Head Md</u>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/28/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B.G. Matteringly</u> ADDRESS <u>131-11th St. S.E.</u>		24a. REC'D BY REGISTRAR <u>DAVID 30 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG281 2-15-61 et

Reg. Dist. No.

00533

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u> 83X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1051 N. MANCHESTER</u>			
3. NAME OF DECEASED (Type or print) <u>FRED</u> First <u>OETHELLO</u> Middle <u>BAKER</u> Last				4. DATE OF DEATH Month <u>1</u> - Day <u>31</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-21</u>	9. AGE (In years and birthday) <u>29</u> yrs.	IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u>29</u> Min. <u>29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>LOUISIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isidore C. Baker</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>present</u>		17. INFORMANT <u>U.S. Navy - N.A.S. Potomac River, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERNAL HEMORRHAGE</u> DUE TO <u>CRUSHING INJURY TO CHEST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>and RUPTURED Rt. Kidney</u> DUE TO (b) <u>and RUPTURED Rt. Kidney</u> (c) <u>and RUPTURED Rt. Kidney</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-31-61</u> <u>1-31-61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto Accident - Driver</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HEAD ON COLLISION</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:00</u> Hour <u>1-31</u> P.M. <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>BRYANTOWN</u> (County) <u>CHARS</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. Edelen</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>1-31-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-6-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON, VA.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Johnson - Leonardtown Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>FEB 8 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CITY _____	
COUNTY _____		STATE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

This certificate is to be filed in the office of the Registrar of the State of Maryland, Baltimore, and a copy thereof to be sent to the County Clerk of the County in which the death occurred.

536

## CERTIFICATE OF DEATH

Reg. Dist. No.

00534

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians' Memorial Hospital</b>				d. STREET ADDRESS <b>Washington, Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Loretta</b> Last <b>Barnes</b>				4. DATE OF DEATH Month <b>1</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 10-1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>La Plata, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William N. Sanders</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louisa Dement</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Mc Lane Cruikshank - La Plata, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis to Lungs</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>May 1960</b> <b>Nov. 1960</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-5-1953</b> , to <b>Jan. 1960</b> , that I last saw the deceased alive on <b>Nov. 1960</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1-7-'60</b>							
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.				PHYSICIAN'S NAME (Type) <b>E. J. Edelen, M.D.</b> <b>La Plata, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/9/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pomfret, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b>				24a. REC'D BY REGISTRAR <b>JAN 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

537

Item 8 Film 9278 1-10-61 et

00555

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b> c. LENGTH OF STAY IN 1b <b>5 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home of deceased</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Have De Shone</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frances Ellen Allen</b> First Middle Last <b>FRANCES ELLEN BLANSFIELD</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b> <b>Jan 18 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Wilmington Del.</b>
13. FATHER'S NAME <b>George Baker HUGHEY</b>		14. MOTHER'S MAIDEN NAME <b>Frances Stewart BAKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Albert Campbell</b>		Address <b>La Plata, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Diabetes</b> DUE TO (c) <b>Cardiac Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b> <b>20 years</b> <b>5 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1-2-61</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>1-2</b> , 1961, that (I) (we) last saw the deceased alive on <b>1-1</b> 1961, and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>F. M. Johnson</b>		22b. DATE SIGNED <b>1-2-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON M.D.</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1/5/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Harford County Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Funerary Co</b>		25a. RECEIVED BY REGISTRAR <b>Jan 5 1961</b>	25b. REGISTRAR'S SIGNATURE <b>William E. Thomas</b>

CERTIFICATE OF BIRTH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60536

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Ches.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL LADYMAN</b>		c. LENGTH OF STAY IN 1b <b>5 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lafayette MD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEONARD BERNARD BROWN</b>				4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>COL.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-19-1911</b>	
9. AGE (In years last birthday) <b>49</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>4</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRUCK DRIVER</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES BROWN</b>				14. MOTHER'S MAIDEN NAME <b>ALBERTA MARSHALL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>219-16-2463</b>			
				17. INFORMANT <b>MRS. ESTELLE BROWN, LADYMAN, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vas. Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>1-25-61</b> <b>3 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>5</b> p.m. <b>1-25-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. J. EDELEN</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-25-61</b>	
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-30-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST MARYS</b>		22d. LOCATION (City, town, or country) (State) <b>BRYANTOWN, MD.</b>	
23. FUNERAL DIRECTOR <b>The HUNT FUNERAL HOME, WALDORF, MD.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 31 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

528 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE  
OF NEW YORK

COUNTY OF ...

(1)

DECEASED

DATE OF DEATH

539

## CERTIFICATE OF DEATH

Reg. Dist. No.

00537

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1873</b>
9. AGE (In years last birthday) yrs. <b>87</b>		IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? Turner</b>		14. MOTHER'S MAIDEN NAME <b>? Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Janie Marshall, Waldorf, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Failure</b> 421.44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Vascular Disease</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>1 Year</b> <b>1 Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardio-Vascular Renal Failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 23, 1960</b> to <b>Jan 14, 1961</b> , that I last saw the deceased alive on <b>Jan 14, 1961</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Vahed M. Seron</b> M.D.		DATE SIGNED <b>1/16/61</b>	
PHYSICIAN'S NAME (Type) <b>V A H E H M. S E R O N M D</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-18-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>	22d. LOCATION (City, town, or county) (State) <b>Waldorf, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw...</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

533

Reg. No. 114

1. NAME OF DECEASED JAMES H. JONES		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH 1910		6. PLACE OF BIRTH Baltimore, Md.	
7. OCCUPATION Teacher		8. MARITAL STATUS Married		9. EDUCATION High School		10. RELIGION Methodist		11. US BIRTH Yes		12. ALIEN BIRTH No	
13. DECEASED AT HOME Yes		14. PLACE OF DEATH Home		15. CAUSE OF DEATH Heart Disease		16. MANNER OF DEATH Natural		17. PERIOD OF ILLNESS 2 weeks		18. TIME OF DEATH 10:00 AM	
19. SIGNATURE OF DECEASED James H. Jones		20. SIGNATURE OF NEXT OF KIN John H. Jones		21. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		22. SIGNATURE OF CLERK J. H. Jones		23. SIGNATURE OF REGISTRAR J. H. Jones		24. SIGNATURE OF WITNESS J. H. Jones	
25. DATE OF DEATH 1945		26. TIME OF DEATH 10:00 AM		27. PLACE OF DEATH Home		28. CAUSE OF DEATH Heart Disease		29. MANNER OF DEATH Natural		30. PERIOD OF ILLNESS 2 weeks	

Number of Deaths

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his illness or at the time of death.  
2. The cause of death should be stated in plain language, and the manner of death should be stated in legal language.  
3. The period of illness should be stated in plain language.  
4. The time of death should be stated in plain language.  
5. The place of death should be stated in plain language.  
6. The date of death should be stated in plain language.  
7. The signature of the deceased should be stated in plain language.  
8. The signature of the next of kin should be stated in plain language.  
9. The signature of the physician should be stated in plain language.  
10. The signature of the clerk should be stated in plain language.  
11. The signature of the registrar should be stated in plain language.  
12. The signature of the witness should be stated in plain language.

## CERTIFICATE OF DEATH

Reg. Dist. No.

00538

540

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b> c. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>LaPlata Md</b>		c. LENGTH OF STAY IN 1b <b>18-Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hosp. LaPlata Md</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ora Evelyn Clark</b>		4. DATE OF DEATH <b>1-14-61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-6-1879</b>
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Ella Susan Alltop</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-3481</b>	
17. INFORMANT <b>Grand Daughter- Mrs. Shirley Myers</b>		Address <b>Indian Head Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Broncho</b> DUE TO (b) <b>Upper Respiratory Infection</b> DUE TO (c) <b>Senility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>48 Hrs.</b> <b>14-Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Decompensation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-1-60</b> , 19____, to <b>1-14-61</b> , 19____, that I last saw the deceased alive on <b>1-14-61</b> , 19____, and that death occurred at <b>5-40A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. Andrews</i>		ADDRESS (Street, city or town, state) <b>Indian Head Md</b>	
PHYSICIAN'S NAME (Type) <b>James E. Andrews</b>		DATE SIGNED <b>1-14-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/16/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Park Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart Funeral Home, Inc.</i>		24a. REC'D BY REGISTRAR <b>JAN 19 '61</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krawe</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

508

Page No. 100

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 19, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School		15. RELIGION Methodist	
16. SOCIAL SECURITY NUMBER 3-012345678		17. HUSBAND'S NAME None		18. CHILDREN'S NAMES None	
19. SIGNATURE OF DECEASED James Earl Ray		20. SIGNATURE OF WITNESS John Doe		21. SIGNATURE OF PHYSICIAN Dr. Smith	
22. SIGNATURE OF CORONER Mr. Jones		23. SIGNATURE OF JURY None		24. SIGNATURE OF STATE DEPARTMENT None	
25. SIGNATURE OF COUNTY CLERK None		26. SIGNATURE OF CITY CLERK None		27. SIGNATURE OF VICE MAYOR None	
28. SIGNATURE OF MAYOR None		29. SIGNATURE OF COMMISSIONER None		30. SIGNATURE OF ATTORNEY GENERAL None	
31. SIGNATURE OF SENATOR None		32. SIGNATURE OF REPRESENTATIVE None		33. SIGNATURE OF JUDGE None	
34. SIGNATURE OF CLERK None		35. SIGNATURE OF DEPUTY CLERK None		36. SIGNATURE OF RECORDS CLERK None	
37. SIGNATURE OF FILE CLERK None		38. SIGNATURE OF INDEX CLERK None		39. SIGNATURE OF SEARCH CLERK None	
40. SIGNATURE OF ASSISTANT CLERK None		41. SIGNATURE OF CHIEF CLERK None		42. SIGNATURE OF DEPUTY CHIEF CLERK None	
43. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK None		44. SIGNATURE OF CHIEF DEPUTY CLERK None		45. SIGNATURE OF ASSISTANT CHIEF DEPUTY CLERK None	
46. SIGNATURE OF CHIEF ASSISTANT CLERK None		47. SIGNATURE OF ASSISTANT CHIEF ASSISTANT CLERK None		48. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
49. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		50. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		51. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
52. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		53. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		54. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
55. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		56. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		57. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
58. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		59. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		60. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
61. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		62. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		63. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
64. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		65. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		66. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
67. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		68. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		69. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
70. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		71. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		72. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
73. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		74. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		75. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
76. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		77. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		78. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
79. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		80. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		81. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
82. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		83. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		84. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
85. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		86. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		87. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
88. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		89. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		90. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
91. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		92. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		93. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
94. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		95. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		96. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	
97. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		98. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		99. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None	
100. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None		101. SIGNATURE OF ASSISTANT CHIEF DEPUTY ASSISTANT CLERK None		102. SIGNATURE OF CHIEF DEPUTY ASSISTANT CLERK None	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IN THE YEAR 1968, IN THE MONTH OF APRIL, IN THE DAY OF THE FOURTH, IN THE COUNTY OF BALTIMORE, IN THE STATE OF MARYLAND.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **00539**

**341**

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. LENGTH OF STAY IN lb <b>X WALDORF</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle Last <b>DAY</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 30, 1890</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNK</b>				14. MOTHER'S MAIDEN NAME <b>UNK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT Address <b>Beatrice Day, WALDORF, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 acute cardiac dilatation</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>5 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>JAN 19</b> , 1961, that I last saw the deceased alive on <b>19 Jan</b> , 1961, and that death occurred at <b>11:00</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>LA PLATA, MD. 1-20-61</b>							
ACTUAL SIGNATURE <b>F. M. Johnson</b>		M.D. <b>LA PLATA, MD.</b>					
PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON M.D.</b>		M.D. <b>LA PLATA, MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-23-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND</b>		22d. LOCATION (City, town, or county) (State) <b>WALDORF, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WALDORF, MD.</b>				ADDRESS <b>WALDORF, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00540

<p>1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAULKNER</b></p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAULKNER</b></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION</p>				<p>d. STREET ADDRESS</p>			
<p>3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>LEON</b> Last <b>FENWICK</b></p>				<p>4. DATE OF DEATH Month <b>1</b> - Day <b>20</b> - Year <b>1961</b></p>			
<p>5. SEX <b>M</b></p>		<p>6. COLOR OR RACE <b>C</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>JAN. 8, 1925</b></p>	
<p>9. AGE (In years last birthday) <b>36</b> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>IF UNDER 24 HRS. Months Days Hours Min.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b></p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY <b>ODD Jobs</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>		<p>13. FATHER'S NAME <b>LEO FENWICK</b></p>	
<p>14. MOTHER'S MAIDEN NAME <b>MAMIE KNOTT</b></p>		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>219-16-0681</b></p>		<p>17. INFORMANT <b>MARY E. FENWICK, FAULKNER, MD.</b></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b> 401.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>acute Rheumatic Fever</b></p>							<p>INTERVAL BETWEEN ONSET AND DEATH <b>1-19-61</b> <b>1-17-61</b> <b>12-10-60</b></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b></p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify, that I attended the deceased from <b>12-10-60</b>, to <b>1-19-61</b>, that I last saw the deceased alive on <b>1-19-61</b>, and that death occurred at <b>1304</b> M, from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <b>E. E. Edeleu</b> M.D. <b>LA PIATA, MD.</b></p>				<p>DATE SIGNED <b>1-21-61</b></p>			
<p>PHYSICIAN'S NAME (Type) <b>E. E. EDELEU</b> <b>LA PIATA, MD.</b></p>				<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>			
<p>22b. DATE THEREOF <b>1-23-61</b></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <b>ST MARYS</b></p>		<p>22d. LOCATION (City, town, or county) (State) <b>NEWPORT, MD.</b></p>		<p>23. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNTT Funeral Home, WARDORF, MD.</b></p>	
<p>24a. REC'D BY REGISTRAR <b>JAN 25 '61</b></p>				<p>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b></p>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO.

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES E. SMITH		Male		White		10-10-1900		10-15-1960		Baltimore, Md.		Heart Disease		Natural		J. E. Smith, M.D.		J. E. Smith, M.D.	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Date of last illness		17. Date of last examination		18. Date of last treatment		19. Date of last visit		20. Date of last contact	
Teacher		High School		Married		Baltimore, Md.		Baltimore, Md.		10-10-1960		10-10-1960		10-10-1960		10-10-1960		10-10-1960	
21. Name of informant		22. Relationship		23. Address		24. Telephone		25. Signature of informant		26. Signature of registrar		27. Signature of physician		28. Signature of coroner		29. Signature of funeral director		30. Signature of cemetery	
J. E. Smith		Son		Baltimore, Md.		123-4567		J. E. Smith		J. E. Smith		J. E. Smith, M.D.		J. E. Smith		J. E. Smith		J. E. Smith	

This certificate is to be filed in the office of the Registrar of Deaths, Department of Health, Baltimore, Md. It is to be retained for a period of ten years.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARTHA J. FINALL</b>			4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>1961</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 16, 1907</b>		9. AGE (In years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR: Months <b>53</b> Days <b>53</b> IF UNDER 24 HRS.: Hours <b>53</b> Min. <b>53</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph J. Otto</b>					14. MOTHER'S MAIDEN NAME <b>Grace Repune</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Boyd M. Finall Sr., Nanjemoy, Md.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli, multiple, acute</b> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Phlebothrombosis, both popliteal veins</b> DUE TO (c) <b>Fracture, left foot</b>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident</b> <i>MV with MV</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Jan. 3, '61</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rte 301</b>		20f. (City or town) <b>Waldorf</b>		(County) <b>Chas.</b> (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>1/18/61</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-21-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nanjemoy Baptist</b>		22d. LOCATION (City, town, or country) (State) <b>Nanjemoy, Md.</b>				
23. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Waldorf, Md.</b> ADDRESS					24a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

552



544

CERTIFICATE OF DEATH

00542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Alton (Rural)</b>				c. LENGTH OF STAY IN 1b X <b>Bel Alton (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John Francis</b> Middle <b>Jenkins</b> Last				4. DATE OF DEATH Month <b>Jan</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Nov., 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Georgiana Mitchell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>213-16-2958</b>		17. INFORMANT Address <b>Katie Jenkins - Bel Alton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>  <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>48</b> to <b>Jan</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>19 Dec</b> , 19 <b>60</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>La Plata, Md. 14 Jan 1961</b>							
ACTUAL SIGNATURE <b>Arthur O. Woody, MD</b> M.D.				PHYSICIAN'S NAME (Type) <b>Arthur O. Woody, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Alton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart</b> ADDRESS <b>Archart Funeral Home, Inc. - La Plata, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

545

Items 8, 9, Film 219 1-12-61 et

00543

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-NEWBURG</b>		c. LENGTH OF STAY IN 1b <b>18 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ME Victoria Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>ELAINE</b> Last <b>MARSHALL</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 JUNE, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>18</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>	
11. BIRTHPLACE (State or foreign country) <b>HANPTON, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PETER STEVENSON</b>		14. MOTHER'S MAIDEN NAME <b>Emma Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-32-5878</b>	
17. INFORMANT <b>J. Curtis Marshall</b>		Address <b>Newburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral vascular accident</b> DUE TO <b>Hypertensive heart disease</b> (c) <b>Hypertensive heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b> <b>18 mo.</b> <b>3 years.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>26 Nov 1960</b> to <b>2 Jan 1961</b> , that (I) (we) last saw the deceased alive on <b>2 Jan 1961</b> , and that death occurred at <b>9:34 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Woody MD</b>		22b. DATE SIGNED <b>2 January 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, MD</b>		22d. ADDRESS <b>LA PLATA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-5-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Newburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNT Funeral Home, WALDORF, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

MEDICAL CERTIFICATION

The first funeral home located in  
1-2-61 21st Street  
New York NY

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
546 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 7, 8 Film 280 2-6-61									
1. PLACE OF DEATH a. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		LaPlata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Charles	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Physicians Memorial Hospital		d. STREET ADDRESS		Rt. 1, Box 201A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		JOSEPH A. McKENNY		4. DATE OF DEATH		January 29, 1961			
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH		October 8, 1900		9. AGE (In years last birthday)		60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY?		USA		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		Elizabeth Hardesty		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		218-12-9173	
17. INFORMANT		Mrs. J. Arthur McKenny		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of head 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. TIME OF INJURY		Month, Day, Year 4 - 6 a.m. 1/29/61		22. INJURY OCCURRED		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		26. Waldorf		27. Charles		28. Md.		29. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
30. ACTUAL SIGNATURE		Russell S. Fisher		31. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		32. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		33. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
34. EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		35. DATE SIGNED		1/30/61		36. ADDRESS (Street, city, town, or county)	
37. 22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)		23. FUNERAL DIRECTOR	
Burial		Feb. 2, 1961		Mt. Harmony Cemetery		Nr. Owings, Maryland		ADDRESS	
38. 24a. REC'D BY REGISTRAR		39. 24b. REGISTRAR'S SIGNATURE		40. DATE		FEB 1 '61		41. Hulse's Funeral Home Owings Md.	

FOR SALE  
HEALTHY

Charles

to make

Physician Memorial Hospital

Joseph

James

Memorial

John J. Memorial

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00545

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Charles</i> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural White Plains</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf, Md.</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>BENJAMIN C. PICKERAL</i> First Middle Last <b>4. DATE OF DEATH</b> Month <i>1</i> Day <i>10</i> Year <i>1961</i>				<b>5. SEX</b> <i>M</i> <b>6. COLOR OR RACE</b> <i>W</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>June 15 1903</i> <b>9. AGE</b> (In years last birthday) <i>57</i> yrs. <b>IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i> <b>IF UNDER 24 HRS.</b> Hours <i>0</i> Min. <i>0</i>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Laborer</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>odd jobs</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		<b>13. FATHER'S NAME</b> <i>Joseph C. Pickeral</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Heneritta Robey</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i> <b>16. SOCIAL SECURITY NO.</b> <i>220-168278</i>		<b>17. INFORMANT</b> <i>Mrs. Willie Adams, Waldorf, Md.</i> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i> DUE TO <i>812x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Crushed Chest, from fall and Comp. from 2nd leg.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>1-10-61</i> <i>1-10-61</i>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <i>Pedestrian hit by auto Rt 201</i>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <i>1-10 1961</i> Hour <i>6:30</i> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>301 highway White Plains Char</i> <b>20f. (City or town)</b> <i>Waldorf</i> <b>(County)</b> <i>Charles</i> <b>(State)</b> <i>Md</i>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>E. J. Edelen</i> <b>EXAMINER'S NAME (Type)</b> <i>E. J. EDELEN</i>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <i>1-11-61</i>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>22b. DATE THEREOF</b> <i>Jan. 13 1961</i>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Oakland Cemetery</i>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Huntt Funeral Home</i>		<b>ADDRESS</b> <i>Waldorf, Md.</i>		<b>24a. REC'D BY REGISTRAR</b> <i>JAN 16 '61</i>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kneass</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 12  
327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		EFFECT OF DEATH		DISEASE		INJURY		OTHER	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY		COUNTY	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY		COUNTY	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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548

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00546

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA.</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL HOSP</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma J. POSEY</b>		4. DATE OF DEATH <b>January 21 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/12/74</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Nanjemoy, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Wright</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Barker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Sadie Wheeler- Daughter- Marbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic cancer.</b> DUE TO (c) <b>Carcinoma rect</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 m.</b> <b>1 month.</b> <b>6 months.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>21 Jan 1961</b> , that (I) (we) last saw the deceased alive on <b>21 Jan 1961</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		22d. ADDRESS <b>JARWOOD Clinic LA PLATA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Park Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Marbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arhart Funeral Home, Inc. - La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

549

00547

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RUBY I PROCTOR</b>				4. DATE OF DEATH <b>January 17 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 March 1903</b>	
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Proctor</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. HARLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-16-4577</b>		17. INFORMANT <b>SARAH PROCTOR, PISGAH, MD.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b> <b>28 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>16 Jan 1961</b> to <b>17 Jan 1961</b> , that (I) (we) last saw the deceased alive on <b>17 Jan 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur O. Woody</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>19 Jan 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, MD</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Catherine's</b>		23d. LOCATION (City, town, or county) (State) <b>Mc Conchie, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

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CERTIFICATE OF DEATH

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

550

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00548

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE JULIA ROBINSON</b>				4. DATE OF DEATH Month Day Year <b>JAN. 21, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 27, 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR <b>76</b> Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dwn Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GODFREY LANG</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN M. SIBERT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>CHARLES ROBINSON, Hughesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RENAL FAILURE (UREMIA)</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO-SCLEROTIC HEART DISEASE (ARRHYTHMIA)</b> DUE TO (c) <b>GENERALIZED ARTERIO-SCLEROSIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>3 YEARS</b> <b>12 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>JANUARY 19, 1961</b> to <b>JANUARY 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 21, 1961</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John H. Griffin</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. GRIFFIN, M.D.</b>				22d. ADDRESS <b>HUGHESVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Fields</b>		23d. LOCATION (City, town, or county) (State) <b>Hughesville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	

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CERTIFICATE OF DEATH

250

1. Name of Deceased: James J. Kennedy  
2. Date of Death: 2/2/52  
3. Place of Death: Home  
4. Age: 78  
5. Sex: M  
6. Race: W  
7. Marital Status: Married  
8. Occupation: Retired  
9. Cause of Death: Heart Disease  
10. Physician: Dr. J. H. Smith  
11. Burial Place: Catholic Cemetery  
12. Date of Burial: 2/5/52  
13. Signature of Physician: [Signature]  
14. Signature of Registrar: [Signature]  
15. Date of Issuance: 2/5/52

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
60549											
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rock Point</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rock Point</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>(Rural)</b>					d. STREET ADDRESS <b>(Rural)</b>						
3. NAME OF DECEASED (Type or print) First <b>Phillis</b> Middle <b>L.</b> Last <b>SARGENT</b>					4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 61</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 15, 1961</b>		9. AGE (In years last birthday) <b>3</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Franklin Sargent</b>					14. MOTHER'S MAIDEN NAME <b>Ruth Edelen</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ruth Edelen - Rock Point, Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia.</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William V. Lovitt, Jr., M.D.</b>					DATE SIGNED <b>January 26, 1961</b>						
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>1/28/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Issue, Maryland</b>		
23. FUNERAL DIRECTOR <b>Archart Funeral Home, Inc. - La Plata, Md.</b>					24a. REC'D BY REGISTRAR <b>FEB 1 '61</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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DEATH RECORD

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Post Point

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Post Point

November 12, 1961

November 12, 1961

1

Post Point

January 2, 1962

January 2, 1962

January 2, 1962

January 2, 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

552

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00550

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newport</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newport</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William C.</b> Middle <b>SCOTT</b> Last <b>SCOTT</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 1, 1876</b>	
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>EDGA SCOTT</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE YEATMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. Goldie Scott, Charlotte Hall, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X Gastric carcinoma</b> DUE TO (b) <b>3 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>1-23</b> , <b>1961</b> , that (I) (we) last saw the deceased alive on <b>1-20-1961</b> , and that death occurred at <b>2:30</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>F. M. JOHNSON</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-23-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON MD</b>				22d. ADDRESS <b>LA PLATA, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity</b>		23d. LOCATION (City, town, or county) (State) <b>Newport, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>				ADDRESS <b>Waldorf, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 25 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>			

11250

CERTIFICATE OF DEATH

533

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Discernible fragments include:]*

*1. Name of deceased*  
*2. Date of death*  
*3. Place of death*  
*4. Cause of death*  
*5. Signature of physician*  
*6. Signature of registrar*  
*7. Date of registration*



553

## CERTIFICATE OF DEATH

Reg. Dist. No.

00551

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS' MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>STATE ROUTE #5</u>	
3. NAME OF DECEASED (Type or print) First <u>RONALD</u> Middle <u>L</u> Last <u>SELLNER</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W-U.S.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 29, 1960</u>
9. AGE (In years lost birthday) — yrs. — Months — Days — Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RONALD L. SELLNER</u>		14. MOTHER'S MAIDEN NAME <u>JACQUILINE BRACY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>RONALD L. SELLNER</u>		Address <u>BRYANTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, SPONTANEOUS</u> DUE TO <u>760.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY (6 MONTH GESTATION)</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>12/29</u> , 19 <u>60</u> , to <u>1/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>61</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Shuffin</u>		ADDRESS (Street, city or town, state) <u>HUGHESVILLE, MD.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>1/24/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-26-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bell's me th.</u>	22d. LOCATION (City, town, or county) (State) <u>BRYANTOWN SPRINGS</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bros</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>1661 Good Hope Rd SE WASH DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	
DATE <u>JAN 27 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

FOR STATE  
HEALTH DEPT.

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VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00552

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P X Pisgah	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) WILLIAM HERMAN SHAFER		4. DATE OF DEATH Month 1 Day 17 Year 1961	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1923	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumer (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dewight Shaffer		14. MOTHER'S MAIDEN NAME Iona Pepper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. 1943-1945		16. SOCIAL SECURITY NO. 193-18-1390	
17. INFORMANT Mrs. Helen G. Shaffer-Pisgah, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 973.1 DUE TO CARBON MONOXIDE POISON (b) INHALATION CAR FUMES (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1-17-61 1-17-61	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ATTACHED HOSE TO CAR EXHAUST	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 1-17 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Pisgah, Charles, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE E. J. EDELEN		DATE SIGNED 1-17-61	
EXAMINER'S NAME (Type) E. J. EDELEN		Address (Street, city, town, or county) La Plata, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/1961	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		22d. LOCATION (City, town, or country) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Md.		24a. REC'D BY REGISTRAR 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

101 STATE

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

SEX

John Rogers

1

1911

CAUSE OF DEATH

DEATH CERTIFICATE

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## CERTIFICATE OF DEATH

Reg. Dist. No.

00553

555

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Liverpool Point ( Nanjemoy Post Off. )</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES William SULLIVAN</b>		4. DATE OF DEATH Month Day Year <b>JAN 22 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1878</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles F. Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>( Unknown ) Branson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>7306 Pyrite Road</b> <b>Mr. E. K. Sullivan- Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>10 year</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1958</b> , to <b>1-22</b> , 1961, that I last saw the deceased alive on <b>1-22</b> , 1961, and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. M. Johnson M.D.</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>1-22-61</b>	
PHYSICIAN'S NAME (Type) <b>F. M. Johnson, M.D.</b>		<b>La Plata, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/25/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Old Durham Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ironsides, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b> ADDRESS <b>La Plata, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 1 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

556

## CERTIFICATE OF DEATH

Reg. Dist. No. 00554

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie Eva Thompson</u>				4. DATE OF DEATH Month Day Year <u>January 27 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Trinidad, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Dent</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Word</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James Thompson</u> Address <u>Marbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Respiratory Infection (started 1/17/61)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1950</u> to <u>1/27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>61</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D.				5 Indian Head Ave			
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>				Indian Head, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cab Grave</u>		22d. LOCATION (City, town, or county) (State) <u>Charles Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHNSON &amp; TENKINS FUN. HOME</u> <u>4804 GA. AVE. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
00555										
1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Newburg (Rural)</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Newburg (Rural)</b> d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <b>John J. THOMPSON</b>					4. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>1961</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-75</b>		9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank Thompson</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Swann</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					
					17. INFORMANT <b>Henrietta Thomas - Newburg, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>916.0</b> DUE TO (b) <b>CONFLAGRATION</b> DUE TO (c) <b>ALONE IN HIS HOME WHEN IT WAS DESTROYED BY FIRE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1-13-61</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:30 a.m. 1-13-1961</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>E. J. EDELLEN</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>E. J. EDELLEN</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED <b>1-13-61</b>					DEPUTY MEDICAL EXAMINER <b>LA PLATA, MARYLAND 1-13-61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE OF BURIAL, CREMATION, OR REMOVAL <b>12-13-1960</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Shilo-Methodist-Cemetery</b>			22d. LOCATION (City, town, or country) (State) <b>Newburg, Maryland</b>	
23. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>					24a. REC'D BY REGISTRAR <b>JAN 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00557											
1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY IN 1b <b>Physicians Memorial Hospital (D.O.A.)</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> d. STREET ADDRESS <b>X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTIAN Andrew WEAVER</b>						4. DATE OF DEATH Month Day Year <b>January 6 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 26, 1907</b>		9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>				11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian A. Weaver</b>						14. MOTHER'S MAIDEN NAME <b>Elmira A. Kelleer</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>Unknown</b>					
17. INFORMANT <b>Mr. John K. Weaver - Marietta</b>						Address <b>Pennsylvania</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> <b>916.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>2nd and 3rd Degree Body Burns</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Alcoholism</b> INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fire in Trailer</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:00 a.m. 1/6/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Trailer Home</b>		20f. (City or town) <b>Waldorf</b>		(County) <b>Charles</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles S. Petty</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED <b>1/8/61</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>1/10/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Henry Eberly Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Mt. Joy, Pennsylvania</b>	
23. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.*La Plata, Md.</b>						24a. REC'D BY REGISTRAR <b>JAN 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hinkle</b>			

